FINANCIAL ASSISTANCE APPLICATION FORM INSTRUCTIONS

MultiCare

This is an application for financial assistance for a procedure at Multicare Ambulatory Surgery Center.

**This application must be completed and returned 7 days prior to the scheduled surgery for consideration*

***MyChart is not available for this application.**

Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. This application uses the Federal Poverty Guidelines to help determine what Financial Assistance Program best fits each patient's needs. After a financial assessment of the patient's income has been completed, the patient's bill will be reduced by 100 percent if their income level is at or below 300 percent of the Federal Poverty Guidelines. If the patient's income level is between 301 percent to 400 percent of the Federal Poverty Guideline, the patient's bill will be reduced according to the below sliding scale.

Poverty Level, Up To		
200%	300%	Up to 400%
Charity Discount		
100%	75%	50%
Patient Responsibility		
0%	25%	50%

What does financial assistance cover? Financial assistance covers medically necessary hospital and clinic-based services provided by MultiCare Health System, depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations. For a list of exclusions, please see our Clinic-Based Financial Assistance Policy, located on our website.

If you have questions or need help completing this application call 1-888-808-2183

You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must complete the information below:

Note: You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number, it will help speed up the processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "N/A." To

submit your completed application with all documentation (by mail, email or fax):

- **Mail to:** Multicare Surgery Center – Financial Assistance, PO Box 29661-2107, Phoenix, AZ 85038-9661
- **Fax to:** 602-314-7902 Attention: Payment Support
- **Email to:** msc.paymentsupportoperations@atlashp.com

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly! You may receive bills until we receive your information

MultiCare

FINANCIAL ASSISTANCE APPLICATION FORM

CONFIDENTIAL

*Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed. **

SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? □ **Yes** □ **No** *May be required to apply before being considered for financial assistance*

Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □ **No**

Is the patient currently homeless? □ **Yes** □ **No**

Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and completed documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____)	Birthdate		Account #
Person Responsible for Paying Bill	Relationship to Patient	Birthdate	Social Security # *(optional)*
Mailing Address _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

Employment status of person responsible for paying bill
□ **Employed** (date of hire: _____)
□ **Unemployed** (how long unemployed: _____)
□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage or who live together.

FAMILY SIZE _____ *Attach additional page(s) if needed*

Name	Date of Birth	Relationship to patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

INCOME INFORMATION

Remember: *You must include proof of income with your application.*

You must provide information on your family's current income. Sources of income include, for example:
– Wages – Unemployment – Self-employment – Worker's compensation – Disability – SSI – Child/spousal support.
– Work study programs (students) – Pension – Retirement account distributions – Other (*please explain below*)

Income verification is required to determine financial assistance.
All family members 18 years old or older must disclose their current income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.
Examples of proof of income include:

- Current "W-2" withholding statement; or
- Current pay stubs (3 months); or
- Most recent income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for unemployment compensation.

Please provide one of the above examples that is a true representation of your most recent income. If you have no proof of income or no income, please attach an additional page with an explanation.

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that MultiCare Health System may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date